STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005042	A. BUILDING: _____ B. WING _____	C 06/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRE HAUTE REGIONAL HOSPITAL	3901 S SEVENTH ST TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a State hospital complaint investigation. Complaint: #IN00150036 Substantiated: No deficiencies related to the allegations are cited. Facility Number: 005042 Survey Date: 06/20/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Terre Haute Regional Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: claughlin 06/25/14	S 000		